

Reset Form

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ICE Health Service Corps

Incident Reporting Document

The information placed on this form is confidential and privileged IAW 42 U.S.C. 11137. **UNAUTHORIZED DISCLOSURE CARRIES A FINE UP TO 20,000.** DO NOT FILE OR REFER TO THIS FORM IN PATIENT RECORD. REPORT EVENT TO SUPERVISOR/DEPARTMENT CHIEF IMMEDIATELY. Email completed to: DIHSQINCIDENTS@dhs.gov This Form must be completed electronically.

1. Date of Event: _____ 2. Time of Event: _____ 3. Name of Facility: _____
 4. Age: _____ 5. Gender: _____ 6. (State in block # 16): ☐ Detainee ☐ Visitor ☐ Staff ☐ Other
 7. Attending Medical Provider: _____ 8. Location of Event: _____
 9. Diagnosis (Medical/Psychiatric if any): _____ 10. Work Related: ☐ Yes ☐ No
 11. Weapons Involved: ☐ Yes ☐ No 12. Witnesses: ☐ Yes ☐ No 12a. Name of Witness: _____

13. Type of Incident/Occurrence:

☐ Adverse Drug Reaction ☐ Equipment ☐ Injury ☐ Pharmacy ☐ Property Loss or Damage
☐ Airborne Exposure ☐ Escape ☐ Medication (to include IV) ☐ Suicide/Suicide Attempt
☐ Bloodborne Exposure ☐ Fall/Discovered on Floor ☐ Medication Administration ☐ Other (Explain in narrative block # 16)

14. Condition After Occurrence (Check one box only):

☐ No Apparent Effect ☐ Minor Injury or Effect ☐ Significant Injury or Effect ☐ Death or Loss of Function
☐ Other (Explain in narrative block # 16)

15. Action Taken

Yes	No		Yes	No		Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Medical Provider Notified	<input type="checkbox"/>	<input type="checkbox"/>	Laboratory Tests Ordered/Taken	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Did Medical Provider See Patient	<input type="checkbox"/>	<input type="checkbox"/>	Reported to Supervisor/ Department Chief	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	X-Rays Ordered/Taken	<input type="checkbox"/>	<input type="checkbox"/>	Transported to Other Health Care Facility	<input type="checkbox"/>	<input type="checkbox"/>
							Other (Explain in narrative block # 16)

16. Description of Event (Concise, Factual, Objective Statements), Include Location of Event:

17. Immediate Intervention (If more space is needed, use a blank sheet of paper for continuation):

Name, Grade, Title of Individual Completing Form (Print)

Signature

Date of Report

For HQ Use Only:

21. Log Number: _____

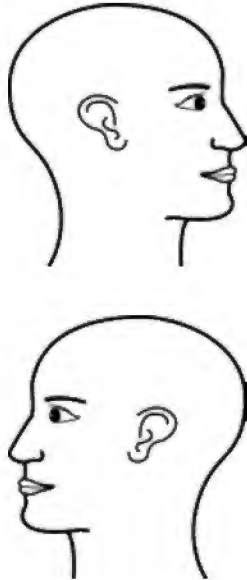
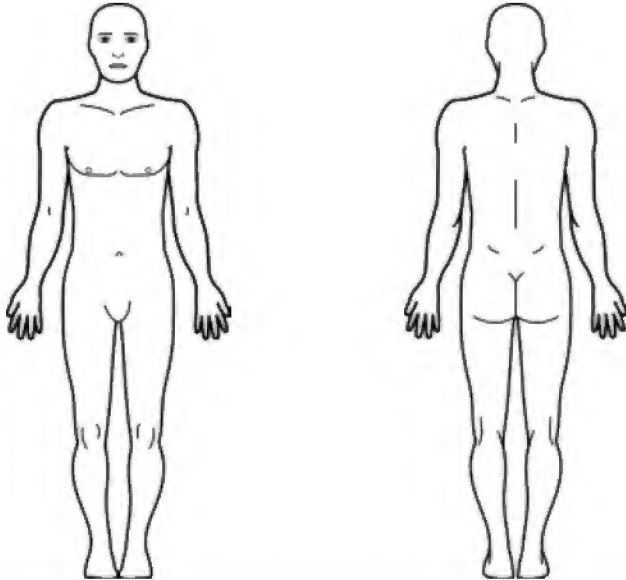
22. Further Analysis Indicated: ☐ Yes ☐ No

Last Name:	First Name:
A#:	Country of Origin:
Date of Camp Arrival (DCA):	DOB:
Medical Clinic:	Sex:

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Incident Reporting Document (Continued)

22. Body Diagram:

	
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23. Evaluation: (Concise Objective Statements e.g., Practice/Procedure variance involving staff. Include other possible contributing factors, etc. and suggested improvement measure if any):

HSA:	Date: _____
Medical Director:	Date: _____
Performance Improvement Committee:	Date: _____

Last Name:	First Name:
A#:	Country of Origin:
Date of Camp Arrival (DCA):	DOB:
Medical Clinic:	Sex: